STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey (KY#22878) was conducted on 03/10/15 through 03/13/15 with deficiencies cited at the highest Scope and Severity of an "E". KY#22878 was unsubstantiated with no deficiencies.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/03/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the Minimum Data Set (MDS) manual (CMS's RAI Version 3.0 Manual), it was determined the facility failed to code the MDS correctly related to weight gain for one (1) of nineteen (19) sampled residents (Resident #2). The findings include: Review of the CMS's RAI Version 3.0 Manual revealed if a resident had experienced a weight gain of five percent (5%) or more in the last thirty (30) days or ten percent (10%) or more in the last one-hundred and eighty (180) days and the weight gain was not planned and prescribed by a physician then it would be coded a two (2) which would indicate the resident had a 10% or more weight gain in the last 180 days. Record review revealed the facility admitted Resident #2 on 01/24/13 with diagnoses which included Diabetes Mellitus and Hypertension. Review of Resident #2's Registered Dietician's (RD) Annual Data Collection/Evaluation of Nutrition, dated 09/18/14, revealed Resident #2 had a 10% weight gain in 180 days; however, review of the annual MDS assessment, dated 09/19/14 revealed Section K0310 for weight gain revealed the resident was coded a "0" for weight gain, indicating the resident had no weight gain. Interview with the Dietary Manager (DM), on 03/12/15 at 8:40 AM, revealed the coding on the MDS for Section K0310 was inaccurately coded. The DM stated Resident #2 had a 10% weight gain over a 180 days and Section K0310 should	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 have been coded as a two (2) to reflect the weight gain. The DM revealed the RD provides the assessment and information for coding the comprehensive MDS assessments and the DM provides the information for the quarterly assessments. Interview with RD, on 03/12/15 at 1:00 PM, revealed the coding on the MDS was inaccurately coded. The RD stated Resident #2 had a 10% weight gain over a 180 day period and Section K0310 should have been coded as a two (2) to reflect the weight gain. Interview with the MDS Coordinator, on 03/12/15 at 8:30 AM, revealed the coding for Section K0310 was inaccurately coded. The MDS Coordinator stated Resident #2 had a 10% weight gain over a 180 day period and section K0310 should have been coded as a two (2), to reflect the weight gain. The MDS Coordinator stated the DM was responsible for coding Section K.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 3	F 280		

and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to revise the comprehensive nutritional care plan regarding the problem statement, goals and interventions for one (1) of nineteen (19) sampled residents (Resident #2). Resident #2 experienced a ten percent (10%) weight gain in 180 days and the care plan and interventions were not revised to reflect these changes.

The findings include:

Review of facility care plan policy dated October 2010 revealed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, (psychological needs) should be developed for each resident. Each resident's comprehensive care plan was designed to reflect treatment goals, timetables and objectives in measurable outcomes. Further review revealed the interdisciplinary team was responsible for reviewing and updating the care plans when there had been a significant change in the resident's condition; when the desired outcome was not met; when the resident has been readmitted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4	F 280		

the facility from a hospital stay; and, at least quarterly.

Record review revealed the facility admitted Resident #2 on 01/24/13 with diagnoses which included Diabetes Mellitus and Hypertension.

Review of the Registered Dietician's (RD) Data Collection/Evaluation Tool, dated 09/18/14, revealed the resident's snacks were frequently in the room and excessive snacking in the room was part of the rationale for the noted excessive weight gain. However, review of Resident #2's Nutrition Care Plan for a weight gain of 10% over six (6) months, dated 09/18/14, revealed there were no interventions to address the excessive snacking.

Further review of the Nutrition Care Plan revealed a goal to remain within a range of plus or minus three (3) pounds of the current weight through next review; however, review of the resident's weight record revealed the resident's weight of 237 pounds on 09/18/14 increased to 245.4 pounds in December 2014. There were no interventions added to address the resident's continued weight gain and the resident's goal was not revised.

Observation and interview with Resident #2, on 03/11/15 at 8:00 AM, revealed there were multiple boxes of various snacks in his/her room and the resident stated the snacks were his/her personal snacks which included chips, crackers and snack cakes along with soda.

Interview with the Dietary Manager (DM), on 03/12/15 at 12:35 PM, revealed the Registered Dietician (RD) implemented the care plan and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5 reviewed the care plan with all annual and comprehensive assessments and the DM reviewed them with quarterly assessments. Interview with RD, on 03/12/15 at 1:00 PM, revealed the DM attended the care plan meetings but the RD completes the care plans for weight gains and losses. The RD stated sometimes the Assistant Director of Nursing (ADON) updated the care plans. Interview with Director of Nursing (DON), on 03/13/15 at 2:45 PM revealed she expected the care plans to have been updated quarterly and with any change of conditions and stated the MDS Coordinator was responsible for monitoring and updating care plans quarterly and annually.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14 , it was determined the facility failed to ensure professional standards of quality were provided for one (1) of nineteen (19) sampled residents (Resident #2). Resident #2 was ordered an antibiotic twice a day for seven days (total of fourteen (14) doses); however, review of the Medication Administration Record (MAR) revealed the antibiotic was not discontinued until after the resident received sixteen (16) doses.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 6	F 281		

The findings include:

Review of the KBN AOS #14 Patient Care Orders, last revised 10/2010, revealed licensed nurses should ensure medications are prepared and administered according the the physician's order.

Review of the facility's policy titled "Medication and Treatment Orders", dated January 2014, revealed orders not specifying number of doses, or duration of medication shall be subject to automatic stop orders. Drugs not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders. One (1) day prior to the stop date the order is to become effective, the nurse supervisor/charge nurse on duty must contact the prescriber or attending physician to determine if the medication is to be continued.

Record review revealed the facility admitted Resident #2 on 01/24/13 with diagnoses which included Diabetes Mellitus and Hypertension.

Review of the Physician Order, dated 03/02/15 at 1:30 PM, revealed an order for Resident #2 to receive Augmentin (antibiotic) 875 milligrams (mg), one (1) tablet by mouth, twice a day for seven (7) days, for Upper Respiratory Infection.

Review of the March 2015 MAR revealed the Augmentin had been initialed as administered twice a day for eight (8) days instead of seven (7) day per the physician's order.

Interview with the Assistant Director of Nursing (ADON), on 03/11/15 at 12:00 PM revealed she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 7 was made aware of the medication error on 03/11/15. The ADON stated the antibiotic order was for seven (7) days but had been given for (8) days. The ADON revealed she expected medications to be administered according the duration specified in the physician's order. Interview with Director of Nursing (DON), on 03/13/15 at 2:45 PM, revealed she expected licensed staff to follow the physicians' orders precisely and stop the orders per the physicians' orders as directed. The DON stated the licensed staff should have put stop dates in the Electronic Medication Administration Records (E-MAR).	F 281		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure food was stored, prepared and distributed under sanitary conditions. Observations on 03/11/15 revealed the range hood with a build up of a rust colored substance; blackened, raised	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 8	F 371		

areas around the base of the walk-in freezer and refrigerator gaskets; the walk-in freezer was noted to have frozen condensation on the ceiling, a patch of ice on the freezer floor and an overhead pipe; two dumpsters, a compactor and an oil pit were not on a solid foundation, sliding doors on the two dumpsters were opened and there was a build-up of debris under the compactor; brown, crusty debris on top of the convection oven; tiles were broken, cracked and/or missing throughout the kitchen and storage areas and were noted to have had a visible build-up of a blackened substance around the grouted areas.

Review of the facility's Census and Condition, dated 03/10/15, revealed there were one-hundred and sixteen (116) residents in the building and six (6) residents who received tube feedings.

The findings include:

Interview with the Dietary Manager (DM), on 03/11/15 at 12:05 PM, revealed there was no policy on the cleaning of the kitchen floors, equipment, freezers, or refrigerators and only assignment sheets to show this had been completed. The DM stated there was no policy on the closing of the dumpster sliding doors or maintenance of that area.

Observation during the initial tour of the kitchen on 03/11/15 at 11:45 AM revealed the following:

1. The range hood was noted to have a build-up of a rust colored substance, directly over the stove top.

2. The walk-in freezer and refrigerator gaskets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 9	F 371		

were noted to have had a blackened substance on the bottom of the gaskets and a blackened build-up on the tiles, grout, around the doorways. A patch of ice was noted on the freezer floor, underneath the two (2) inch wrapped pipe which had four (4) inches of ice build-up around the bend of the pipe.

3. The area beneath the two dumpsters, a compactor and an oil pit was graveled and had a build-up of debris and wet, gray matter, underneath the compactor. All four of the sliding doors on the dumpsters were opened.

4. A build-up of brown, crusty debris was noted on top of the convection oven, where two trays of food items for the noon meal were sitting.

5. Throughout the kitchen and storage areas there were broken, cracked or missing tiles and the grout was noted to have a thick build up of a blackened substances.

Interview with the Dietary Manager on 03/11/15, at the time of the observation, revealed she was not aware of the rust colored substance on the range hood and stated the hood vents were periodically cleaned but was unsure the last time the inside of the hood and over the stove top, had been cleaned and this was not on the cleaning assignment sheets. She stated the refrigerator and freezer gaskets were blackened on the bottom, due to the build-up of blackened substances on the grout and tile, below the gasket and the refrigerator and freezer seals sweep the blackened substances back and forth each time the doors are opened. She revealed the dietary staff members were aware of the need to keep the dumpster lids closed, but she was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10	F 371		

aware the dumpster needed to have been on a solid surface. She stated the ice build up on the pipes had previously been addressed and cleaned, however, this returned frequently. She revealed the floors were on a cleaning schedule, as well as the cleaning of the convection oven and floors were to have been cleaned and mopped after meals and she was unaware of a deep cleaning done periodically on the tiles and grout.

Review of the cleaning schedules for the kitchen and storage area, for March 2015, revealed several empty blocks where staff were to have initialed the assignment was completed.

Interview with the Dietary Manager, on 03/11/15 at 12:05 PM, revealed she reviewed the assignment sheets each Friday. However, she had not determined why there were empty holes on the cleaning schedule and had not interviewed staff or followed up to determine if the cleaning had been done and not initialed.

Interview with the Maintenance Director on 03/12/15 at 12:30 PM, revealed he had no policy on maintenance of the kitchen floors or the dumpsters and he was not aware of the need for a solid foundation under the dumpsters.

Interview with the Director of Nursing (DON), on 03/13/15 at 2:50 PM, revealed she had never went directly to the nursing staff to remind them to keep the sliding doors on the dumpsters closed, however, she was sure they had been made aware to do this.

Interview with the Administrator, on 03/13/15 at 3:50 PM, revealed the floors in the kitchen were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 some of the oldest flooring in the building and he was aware they possibly needed replacing. He also stated he was unaware of the need for the dumpsters to have been on a solid foundation.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure proper infection control measures to maintain a safe and sanitary environment to prevent the transmission of disease and infection for one (1) of nineteen (19) sampled residents (Resident #7) and on unsampled resident (Unsampled Resident A). The findings include: 1. Review of the facility's policy titled, "Assisting the Resident In-Room Meals", dated April 2001, revealed employees must wash their hands before serving food to residents. Review of facility's policy titled, "Assistance with Meals", dated October 2013, revealed all employees who provide resident assistance with meals should be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. Observation on 03/12/15 at 8:31 AM revealed Resident #7 was sitting in his/her Broda chair with a meal tray placed in front of him/her. Certified Nursing Assistant (CNA) #1 was observed entering Resident #7's room then proceeded to take her left hand to touch her hair and placed her hair behind her ear. CNA #1 failed to wash	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 his/her hands and proceeded to touch Resident #7's clothing protector and remove the plastic from two (2) cups containing a clear liquid. Additionally, CNA#1 unwrapped the eating utensils and sweetener packet and stirred Resident #7's oatmeal. Resident #7 then picked up that same spoon and began to eat his/her oatmeal. Interview with Resident #7, on 3/13/15 at 2:15 PM revealed Resident's expectation was for staff to have clean hands when serving his/her meal and would have expected staff to sanitize their hands if they had touched their hair. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment, dated 02/19/15, revealed the resident's cognition was moderately impaired with a Brief Interview for Mental Status(BIMS) score to be "12" indicating the resident was interviewable. Interview with CNA #1, on 03/12/15 at 8:40 AM, revealed she should have sanitized her hands before serving Resident #7's tray and stated that she would have used hand sanitizer if she had it to do over again. CNA#1 stated she was nervous and was just not thinking at the time. CNA #1 revealed her hand sanitizer was in her pocket and that she should have used it. Interview with Director of Nursing (DON), on 03/12/15 at 8:55 AM, revealed she expected staff to follow policy and procedure and use proper sanitation when handling resident's meals.	F 441		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185006	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	201 SOUTH WARREN STREET MORGANTOWN, KY 42261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 14 efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During the Life Safety Code (LSC) survey, conducted 03/12-13/15, there were deficiencies cited which were cited on the previous annual survey (01/16/14) because it had not been corrected. (Refer to K-0025 and K-0072). The findings include: Interview, on 03/13/15 at 11:25 AM, with the Administrator revealed he had re-educated the Plant Operations Director on the requirements for maintaining smoke barriers and he had checked smoke barriers himself and found no concerns as per the facilities plan of correction dated 02/21/14. In addition, the Administrator stated the Quality Assurance Committed had not received any concerns related to storage.	F 490		